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Health Education
MODEL CURRICULUM

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Physical Education, Recreation, and Dance

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The Ohio Association for Health, Physical Education, Recreation and Dance (OAHPERD) Health Education Model Curriculum is a major contribution to OAHPERD fulfilling its vision of "keeping Ohioans healthy and active for a lifetime" The OAHPERD Health Education Curriculum provides essential knowledge and skills that can be transferred to young people's lives, ensuring their preparation for an active and healthy life now and for years to come.

This model curriculum provides local school districts in Ohio with the resources and framework to create a standards-based, skill focused health education curriculum that can be adjusted to meet the local needs within a district. Our young people face daily challenges and pressures that could have a negative influence on their health and wellbeing. The OAHPERD Health Education Model Curriculum provides young people with the knowledge and skills to make healthy choices that can help to prepare them for success in their educational careers and beyond.

The OAHPERD Health Education Model Curriculum would not have been possible without the hard work and leadership of Dr. Kevin Lorson. In addition, on behalf of OAHPERD, I extend my sincere appreciation to Mt. Sinai, Health Policy Institute of Ohio, and the various stakeholders on the Advisory Committee for their important contributions to the construction of this curriculum.

The potential of this curriculum to positively impact the lives of young people in Ohio schools is boundless.

Sutherland

Sue Sutherland, Ph.D.
OAHPERD President

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The Ohio Association for Health, Physical Education, Recreation, and Dance

Ohio Health Education Model Curriculum project overview

Prepared by the Health Policy Institute of Ohio

Ohio ranks 46th on health value, meaning that Ohioans are less healthy and spend more on health care than people in most other states.[1] Examples of Ohio's greatest health challenges include its high rates of adult smoking, drug overdose deaths and cardiovascular disease. Multiple factors, including healthy behaviors, influence these outcomes. Health education builds health knowledge and skills, increasing health literacy and encouraging healthy decisions.

Status of health education in Ohio

Ohio law requires students to earn one-half unit (i.e., complete 60 hours) of health education to graduate from high school. In addition, schools must:

- Teach health education in grades K-8 (no explicit time requirement)
- Have a health education curriculum that includes specific, mandated topics (such as nutrition and "venereal disease")

For subjects other than health, such as English Language Arts, mathematics, technology and financial literacy, Ohio schools have access to academic content standards and model curricula through the Ohio Department of Education (ODE). ODE is not permitted to adopt standards or disseminate a model curriculum for health education without approval by the Ohio legislature. This means:

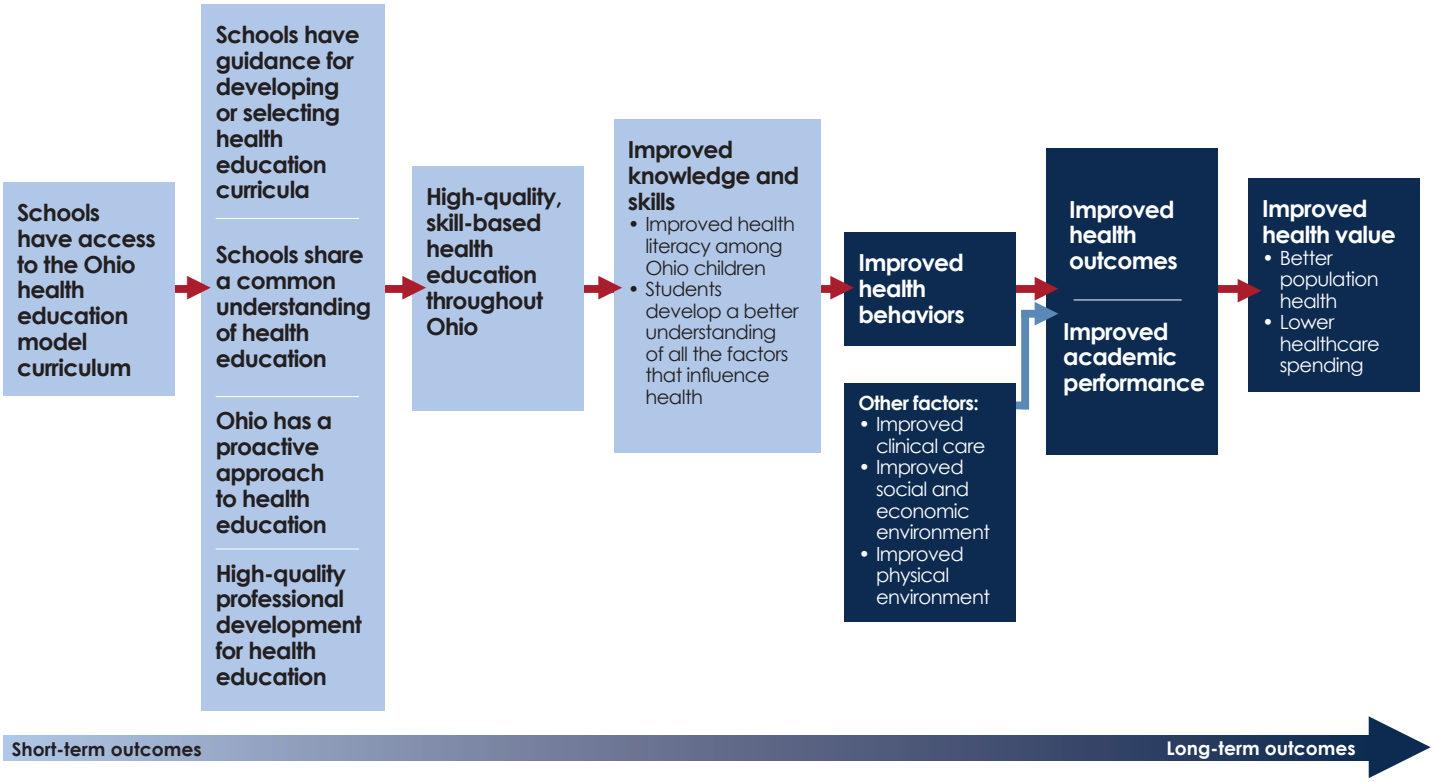
- Schools have no guidance from the state for developing or selecting health education curricula, and teachers lack guidance on how to teach health topics
- There is no uniformity in health education across Ohio and no clear sense of what students are learning

Ohio Health Education Model Curriculum project

The Ohio Association for Health, Physical Education, Recreation and Dance (OAHPERD)[2] regularly receives requests from schools for health education curriculum guidance. In order to assist these schools, OAHPERD convened expert writing teams, made up of Ohio educators and other specialists, to develop a model curriculum for health.

A model curriculum is in-depth guidance on the skills and knowledge students should learn in each grade. It is an optional tool that school districts and educators can use to develop local curricula and instructional plans and structure professional development.

Figure 1. **Purpose of the health education model curriculum project**



Purpose

The primary objective of this K-12 model curriculum is to guide Ohio schools to adopt a comprehensive, skill-based approach to health education. This will provide young Ohioans with the knowledge and skills needed to develop health literacy and become successful learners and healthy, productive adults (see figure 1).

Long-term outcomes of the model curriculum include improved health behaviors, health outcomes and academic performance. Achievement of these outcomes will require partnerships and alignment with efforts at the local and state levels.

The health education model curriculum aligns with ODE's 2019-2024 Strategic Plan and complements other state agency work. It is also a tool schools can use to collaborate with community and health partners, such as Boys and Girls Clubs, after-school programs, public health departments and healthcare providers.

Process and stakeholder engagement

In addition to the expert writing teams, an advisory committee provided input on the creation, components and structure of the model curriculum. The committee included representatives from more than 60 health and education organizations around the state. Any stakeholders expressing interest were invited to participate. The committee met three times, and members were given several opportunities to submit comments on the model curriculum drafts. OAHPERD contracted with the Health Policy Institute of Ohio to assist with stakeholder engagement and meeting facilitation, as well as write this summary.

Final Ohio Health Education Model Curriculum

The final health education model curriculum is available on the **OAHPERD website**. It includes standards aligned with the National Health Education Standards (see box below), prioritization charts outlining which standards are most important for focus in each grade and topic area, and additional materials to support local curriculum development.

The expert writing teams developed detailed student learning outcomes (i.e., benchmarks and indicators) based on Ohio's unique needs. Learning outcomes and content frameworks focus on eight topic areas[3]:

- Alcohol, tobacco and other drug prevention
- Healthy eating
- Human growth and development
- Healthy relationships
- Mental and emotional health
- Personal health and wellness
- Safety
- Violence prevention

National Health Education Standards

The National Health Education Standards were first developed by the Joint Committee on National Health Education Standards in 1995 and have since been reviewed and revised.

Students will:

1. Comprehend concepts related to health promotion and disease prevention to enhance health.
2. Analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.
3. Demonstrate the ability to access valid information and products and services to enhance health.
4. Demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.
5. Demonstrate the ability to use decision-making skills to enhance health.
6. Demonstrate the ability to use goal-setting skills to enhance health.
7. Demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.
8. Demonstrate the ability to advocate for personal, family, and community health.[4]

Notes

1. Health Policy Institute of Ohio. *2019 Health Value Dashboard*. April 2019.
2. OAHPERD represents over 600 Ohio health education and physical education teachers committed to a healthy and physically active Ohio.
3. All topics which Ohio law requires schools to teach are included.
4. *National Health Education Standards: Achieving Excellence*. Joint Committee on National Health Education. Atlanta, GA: American Cancer Society, 2007.

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OAHPERD Health Education Model Curriculum

Introduction

Health and wellness are key elements to Ohio's future. School health education plays a key role in developing our students' knowledge and skills for a healthy future. Health education focuses on reducing health-risk behaviors and promoting healthy decision-making. The Ohio Association for Health, Physical Education, Recreation and Dance (OAHPERD) Health Education Model Curriculum was established to support Ohio's schools in developing a quality health education curriculum focused on the development of the essential skills needed to adopt healthy behaviors.

Ohio faces many health challenges that impact our students, families, and schools. Ohio ranks 46th on health value, which means that Ohioans are less healthy and spend more on health care than residents of almost every other state (Health Policy Institute of Ohio 2019). Ohio faces multiple health crises, including unintentional drug overdose deaths, mental health, and chronic disease. Last year, 13 Ohioans died each day from an unintentional overdose (Ohio Department of Health 2018). Approximately five people per day take their own lives in Ohio (Ohio Alliance for Innovation in Population Health 2019). Suicide rates have more than doubled for children aged 8 to 17 and increased nearly 1.5 times for those aged 18–25 (Ohio Alliance for Innovation in Population Health 2019). Obesity and chronic disease are the most common causes of death and disability, with an economic impact of approximately $56.8 billion per year (Robert Wood Johnson Foundation 2018). Ohio is one of six states to experience a significant increase in obesity rates from 2016 to 2017, and it has the 11th-highest obesity rate, at 33.8% (Robert Wood Johnson Foundation 2018). One-third of 10–17-year-olds are overweight, and 18.6% are obese (Robert Wood Johnson Foundation 2018). While these statistics paint a bleak picture for the health of Ohio, there has been a renewed emphasis on health as we have come to understand the clear connections between education and health in achieving our full potential.

A strong relationship exists between education and health. People with higher levels of education live in healthier communities, practice health behaviors, have better health outcomes, and live longer lives than those with less education (Health Policy Institute of Ohio 2019). Education can impact health by supporting healthy communities, improving access to health care, and improving health literacy and health behaviors. Health impacts education outcomes through attendance, health-related learning obstacles, and school engagement. Health education is one aspect that cuts across both health and education and is one component of a school's approach to educating the whole child. A whole-child approach is an effort to transition from a focus on academic achievement to one that involves the whole school and community to meet students' comprehensive needs.

Ohio continues to evolve as it integrates a whole-child approach to policy, practices, and priorities. The Ohio Department of Education Strategic Plan #EachChildOurFuture emphasizes a whole-child approach and includes health education as part of a well-rounded education. The RecoveryOhio Advisory Council (RecoveryOhio Advisory Council 2019) identified the need for health standards in Recommendations #23. The 2020-2021 state budget (HB 166) provided a $20-million appropriation for K-12 drug prevention education focused on making healthy decisions. The budget also includes a $675-million investment in student supports and wrap around services to build a healthy future for Ohio (Ohio House Bill 166, 2019). Quality school health education serves as an essential component in developing healthy students and a healthy Ohio.

As a content area, Health Education has suffered from a lack of guidance from the state beyond minimum time requirements and topics to address. Ohio is currently the **only** state without health education standards (Raffle, et al. 2019). Health education is the **only** required academic content area without standards in Ohio (Raffle, et al. 2019). The Ohio Department of Education (ODE) provides guidance to support the implementation of Ohio Revised Code (ORC) requirements, but no additional curriculum support has been provided due to the Ohio General Assembly's oversight of health education standards (Raffle, et al. 2019). The requirements for health education in Ohio are limited to .5 units or one semester (minimum of 60 hours) for graduation (Ohio Department of Education 2018). Each school is required to prescribe a health education curriculum in Grades K–8 (Ohio Department of Education 2018). The ORC also requires schools to include specific topics within the local curriculum (See Ohio Department of Education Health Education). However, most elementary schools are not providing a health education curriculum that meets Ohio's minimum requirements (Ohio Department of Health 2015). It is estimated that one-third of middle school students are receiving health education (Raffle, et al. 2019). Students who receive middle school health education typically receive one quarter (9 weeks) or one semester (18 weeks) of such education in one grade level (Raffle, et al. 2019).

Ohio needs a school health education model curriculum that will guide the development of exemplary, skills-based health education. A recent study found that only 42.4% of schools have updated their curriculum within the last five years (Raffle, et al. 2019). The remaining districts either have an older curriculum (30.6%) or do not know (27.2%) where they might find their curriculum (Raffle, et al. 2019). Teachers lack training in health education curriculum development and in the teaching of key topics. An Ohio Department of Health study (2015) estimated that only 29.6% of teachers had professional training regarding alcohol, tobacco, and other drugs within the last two years (2013-2014). The OAHPERD Health Education Model Curriculum is designed to provide guidance for developing a local curriculum that will meet students' diverse needs and promote healthy behaviors.

OAHPERD Health Education Model Curriculum Project Overview

Local school districts, curriculum directors, and health education teachers frequently request professional development and support to develop a high-quality health education curriculum. OAHPERD is a professional organization for Ohio health education, physical education teachers, and other professionals who are committed to keeping Ohioans healthy and active. OAHPERD goals focus on providing professional development, leadership, service, and advocacy. OAHPERD members led the development and implementation of the Ohio Physical Education Standards, Physical Education Evaluation, and the Physical Education Model Curriculum. Based on the success of the physical education initiatives and the limited guidance from the state, OAHPERD has recognized the urgent need to support health educators with the tools needed to build a quality health education curriculum. The Mt. Sinai Health Care Foundation and OAHPERD share the common goal of supporting a healthy Ohio and face similar challenges in supporting quality school health education. Together, the organizations have sought to build a tool that will enhance skills-based health education curriculum in Ohio. The Mt. Sinai Health Care Foundation has supported OAHPERD in convening writing teams to develop the materials needed to develop the OAHPERD Health Education Model Curriculum during 2018-2019. OAHPERD has developed the curriculum materials with input from teachers, curriculum directors, administrators, professional organizations, agencies, and stakeholders throughout the state. OAHPERD has also partnered with The Health Policy Institute of Ohio to convene state and local stakeholders in an Advisory Committee to ensure that the OAHPERD Health Education Model Curriculum is comprehensive, developmentally appropriate, and meets Ohio's unique local and state needs.

Purpose

The purpose of the OAHPERD Health Education Model Curriculum is to provide local school districts with guidance and support in developing a comprehensive K–12, skills-based approach to health education curriculum.

Goals

The mission of OAHPERD is to keep Ohioans healthy and active by providing lifelong learning and professional development, leadership, service, and advocacy. The Health Education Model Curriculum supports OAHPERD's mission through quality skills-based health education that will enhance health literacy and help students adopt and maintain healthy behaviors so they can become successful learners and healthy, productive adults. The OAHPERD Health Education Model Curriculum has four goals:

1. Identify learning outcomes for health education for Grades K–12.
2. Align the learning outcomes to topic areas (e.g. healthy eating, healthy relationships, safety) and provide materials (e.g. Priority Charts) to guide local curriculum development.
3. Provide content frameworks that link skills-based learning outcomes to topic areas and provide resources for teachers to develop a local curriculum.
4. Develop guidance and support documents to help local districts implement a K–12, skills-based health education curriculum to meet students' needs.

Health Education

Health education encompasses planned learning experiences that provide the opportunity for students to acquire functional knowledge and skills needed to make healthy decisions. Health education incorporates a variety of physical, social, emotional, and other components focused on reducing health-risk behaviors and promoting healthy decision-making. Health education curricula emphasize a skills-based approach to help students practice and advocate for the health needs of themselves, their families, and their communities. Health education is a key component of a Whole School, Whole Community and Whole Child (WSCC) approach. A WSCC approach incorporates additional programs and opportunities to enhance health, including a safe and healthy school environment, prevention programming, social-emotional learning, physical education and physical activity programs, health services, health-related programs for families and staff, and the establishment of strong family and community connections.

The goal of K–12 health education is to help students adopt and maintain healthy behaviors. The development of health literacy is presently considered to be essential for students to obtain the goal of adopting and maintaining healthy behaviors. Health literacy is the degree to which individuals have the capacity to obtain, process, and understand the basic health information needed to adopt healthy behaviors (Joint Committee on National Health Education Standards 2007). Health education is the environment in which students have opportunities to practice skills needed to access valid and reliable health information, set achievable health goals, make healthy decisions, use products effectively, and advocate for their own health.

Students must have opportunities in Grades K–12, within a daily health education class led by a licensed health education teacher, to gain the content knowledge and practice the skills that will lead to the adoption and maintenance of health-promoting behaviors. Health education builds on students' knowledge, skills, and attitudes around health. A health education curriculum should be comprehensive, focusing on the physical, mental, social, and emotional aspects of health. School health education can motivate students to improve and maintain their health, prevent disease, and reduce risky behaviors.

A quality health education program includes a licensed health education teacher and a sequential curriculum spanning kindergarten through high school. The curriculum should align with the eight National Health Education Standards (NHES):

Standard 1. Students will comprehend concepts related to health promotion and disease prevention to enhance health.

Standard 2. Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.

Standard 3. Students will demonstrate the ability to access valid information, products, and services to enhance health.

Standard 4. Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.

Standard 5. Students will demonstrate the ability to use decision-making skills to enhance health.

Standard 6. Students will demonstrate the ability to use goal-setting skills to enhance health.

Standard 7. Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.

Standard 8. Students will demonstrate the ability to advocate for personal, family, and community health.

The NHES were first published in 1995 by the Joint Committee on National Health Education Standards. The committee members included experts from the American Public Health Association, American School Health Association, and the Society of Health and Physical Educators, with the support of the American Cancer Society. Over the last decade, the NHES has become the accepted reference in school health education and represents the framework for 49 other states. The NHES were reviewed and revised beginning in 2004, with the updated NEHS released in 2007. The Health Education Curriculum Analysis Tool (HECAT) is an accompanying resource that can help schools select and develop appropriate and effective curricula and improve the delivery of health education. Young people should have the opportunity to learn and practice these content and skill standards through school health education courses offered each year. When students are equipped with the knowledge and ability to analyze, interpret, and access health information, services, and products in ways that are health-enhancing, they will likely lead safer, healthier, and more productive lives.

Skills-based Health Education

Previously, health education was information-based, with students learning only personal health information. However, today's approach to health education prioritizes the health-related skills needed for students to adopt and maintain healthy behaviors. The OAHPERD Health Education Model Curriculum embraces this approach by including essential and functional health education knowledge that can be applied to seven health-related skills.

A skills-based approach represents a paradigm shift for school health education, from presenting information to students to engaging students in lessons to develop the skills necessary to *apply* that information. Students do not just need facts, figures, and information about their bodies, they need essential knowledge that is functional and useful to apply health-related skills in their lives. Skills-based health education uses a planned, sequential, comprehensive, and relevant curriculum to develop the skills, attitudes, and functional knowledge needed to live a healthy life. A planned and sequential curriculum has a logical order, builds upon prior learning, and helps students develop functional knowledge and skills in all dimensions of health and wellness (i.e., physical, social, emotional, mental, environmental). A relevant curriculum is significant, engaging, considerate, and meaningful in considering all students' needs and interests. A skills-based health education curriculum also uses participatory methods, specifically the time to practice and develop the skills required to gain proficiency. More information about skills-based health education can be found throughout this document.

Health Education Requirements in Ohio

Ohio law does not permit the State Board of Education to adopt Health Education Standards, but it does require districts to prescribe a curriculum for health education for all schools under its control. Ohio requires a minimum of one-half unit of health education in high school. One-half unit is equal to a minimum of 60 hours of instruction (Ohio Department of Education 2018). Students could complete the course in a classroom setting, via another delivery system, or by meeting the district's credit flexibility requirements (See the Ohio Department of Education credit flexibility guidelines). If a student is completing the health education requirement online, then the online health education curriculum must align with the district's health education curriculum and include all the required Ohio health education topics. If a district is providing the opportunity to earn high school credit in middle school (i.e., "Advanced Credit"), then the students must complete the high school curriculum to earn graduation credit. Please see the Ohio Department of Education Health Education page for additional information on these requirements.

ORC 3313.60 requires schools to teach specific topics in health education. Table 1 outlines the requirements in each grade band identified by ORC 3313.60. The ORC requirements provide minimal

guidance for the topics that must be addressed within a health education curriculum. The requirements do not identify what students are learning or provide guidance for curriculum development. Instead, they concentrate only on addressing topics with a knowledge/information focus rather than skills-based learning outcomes.

Table 1. Ohio Health Education Requirements

Grades K–6	Grades 7-8	High School
• Nutritive value of foods, including natural and organically produced foods, relation of nutrition to health, and the use and effects of food additives. • Harmful effects of and legal restrictions against the use of drugs of abuse, alcoholic beverages, and tobacco. • Prescription opioid abuse prevention, • Instruction in personal safety and assault prevention*	• Nutritive value of foods, including natural and organically produced foods, relation of nutrition to health, and the use and effects of food additives. • Harmful effects of and legal restrictions against the use of drugs of abuse, alcoholic beverages, and tobacco. • Prescription opioid abuse prevention • Dating violence prevention, including instruction in recognizing dating violence warning signs and characteristics of healthy relationships.* • Venereal disease education*	• Nutritive value of foods, including natural and organically produced foods, relation of nutrition to health, and the use and effects of food additives. • Harmful effects of and legal restrictions against the use of drugs of abuse, alcoholic beverages, and tobacco. • Prescription opioid abuse prevention • Dating violence prevention, including instruction in recognizing dating violence warning signs and characteristics of healthy relationships.* • Venereal disease education* • Process of making an anatomical gift with an emphasis on organ and tissue donation.

*Note. * denotes a topic eligible for a parent exemption.*

Teaching and Learning in Ohio

The OAHPERD Health Education Model Curriculum aligns with ODE guidelines and principles for the development of state standards and model curricula. The ODE provides additional information about the connection between Ohio's Learning Standards, Model Curriculum, Assessments and Resources (see Ohio Department of Education: Learning in Ohio). Ohio, like many states, is considered a local control state. This means that local school boards, not the ODE, have the authority to determine policy, select a curriculum, and establish procedures for many areas in accordance with Ohio school law. It is the role of the ODE to provide guidance using standards and data-informed policy. In most subject areas, ODE approves the standards after completing a comprehensive process that includes development by an educator writing team, opportunities for public feedback, and finally approval by the State Board of Education. Local districts then develop a curriculum aligned with the standards and state requirements to best fit local needs. For additional information about Ohio's learning standards for other content areas, visit http://education.ohio.gov/Topics/Learning-in-Ohio/OLS-Graphic-Sections/Learning-Standards.

The OAHPERD Health Education Model Curriculum was designed with the same principles and intent as the other content areas. The purpose of the OAHPERD Health Education Model Curriculum is to provide learning outcomes, guide the development of local curriculum, and help districts align local needs with the curriculum to best meet student needs. The OAHPERD Health Education Model Curriculum is not designed to replace a local curriculum. It is not intended to identify topics that must be taught, give instructions for how to teach topics, provide lesson plans, or serve as an exhaustive list of classroom activities. It does not replace local district policy, practices, or decision-making. We recommend districts use the Health Education Model Curriculum to support a curriculum development process that is inclusive of all stakeholders.

Quality Health Education in Ohio

Skills-based Health Education

As the focus of K–12 health education has evolved from mere knowledge acquisition to skills development, it is imperative for teachers and curriculum directors to understand the principles of skills-based health education. Skills-based health education is a formidable tool for addressing health-risk behaviors as well as achieving and sustaining health-related behavior change (Hale, Fitzgerals-Yau and Vine 2014). The skills-based approach focuses on the development of functional knowledge, health-enhancing personal beliefs, and seven essential skills, including interpersonal communications, decision-making, goal-setting, and advocacy for self and others. This approach to health education combines critical and creative thinking with student-centered strategies that trigger more participation and discussion as well as multiple opportunities to practice each skill in a variety of health content areas.

Moreover, evidence is increasingly pointing to a strong relationship between exemplary skills development and health-related behavior change: the goal of health education.

The skills present in Standards 2–8 apply across many health education topics. Students need multiple opportunities to practice and apply these skills. The functional knowledge developed by meeting Standard 1 serves as a framework for teaching a skill. For example, the skill of interpersonal communication (Standard 4) could be taught and practiced in the content area of violence prevention with an emphasis on conflict management. Standard 4 might also be taught in the context of Alcohol, Tobacco and Other Drugs (ATOD) with an emphasis on refusal skills. Using the example of violence prevention, one way to assess student proficiency in conflict management would be to provide a violence-related scenario and then ask the students to demonstrate effective conflict management skills for addressing the situation in that scenario. In fact, nearly all seven skill standards could be taught in any of the health education content areas.

Skills-based health education requires a sequential, comprehensive, five-step skill development process, including:

1. Discuss the importance and relevance of the skill to the students' lives as well as how the skill relates to other learned skills.
2. Present the steps (process) for developing the skill.
3. Model the skill for the students.
4. Practice the skill using real-life scenarios (whole group, then partners).
5. Provide feedback and reinforcement.

Skills must be reinforced with multiple practice opportunities to enhance students' proficiency in and ability to transfer the skills to their everyday lives. Developing skills using the skills development process represents a means for developing self-efficacy. Self-efficacy, the belief in one's ability to successfully do something, is the key to adopting healthy behaviors as part of a lifestyle (Bandura 2004). Our goal is to help students adopt healthy behaviors, an aim which requires consistently teaching the seven health-related skills in order to increase the likelihood of Ohio students leading lives of health and wellness.

Developing Local Health Education Curriculum

Health education can contribute to significant improvements in students' health-related behaviors. Today's state-of-the-art health education curricula reflect a growing body of research that emphasizes the following:

- Teaching functional health information (essential knowledge)
- Shaping personal values and beliefs that support healthy behaviors
- Shaping group norms that value a healthy lifestyle
- Developing the essential health skills necessary to adopt, practice, and maintain health-enhancing behaviors.[1]

There are three steps for developing a quality skills-based health education curriculum. These three steps will help guide local processes and decision-making.

Step 1: Start with the Outcomes

The learning outcomes (Standards, Benchmarks, and Indicators) serve as the foundation and will drive the curriculum development process. The HECAT identifies the health behavior outcomes considered most important for promoting in a K–12 health education curriculum. The curriculum development process should therefore identify these health behavior outcomes, while achieving the aligned learning outcomes at various grade levels would serve to promote the health behavior outcomes. Local districts and schools should identify the learning outcomes, develop assessments to track student progress, and then guide learning experiences and skills practice in the classroom to achieve these outcomes. Standards support teachers in identifying learning outcomes and setting the foundation for the curriculum development process. Identifying learning outcomes is also key to aligning various programs and initiatives in the school and community that support students' healthy behaviors.

Step 2: Use Characteristics of Effective Health Education to Guide Instruction

The Characteristics of Effective Health Education were formulated from reviews of effective programs and curricula and from input from experts in the field of health education. These characteristics were designed to guide curriculum development, but they could also be used to design exemplary health education lessons. The characteristics emphasize "teaching functional health information or essential concepts; shaping personal values that support healthy behaviors; shaping group norms that value a healthy lifestyle; and developing the essential health skills necessary to adopt, practice, and maintain health-enhancing behaviors."

The 15 Characteristics of Effective Health Education Curricula (Centers for Disease Control and Prevention 2015):

1. Focuses on clear health goals and related behavioral outcomes.
2. Is research-based and theory-driven.

[1] https://www.cdc.gov/healthyschools/sher/characteristics/index.htm

3. Addresses individual values, attitudes, and beliefs.
4. Addresses individual and group norms that support health-enhancing behaviors.
5. Focuses on reinforcing protective factors and increasing perceptions of the personal risk and harmfulness of engaging in specific unhealthy practices and behaviors.
6. Addresses social pressures and influences.
7. Builds personal competence, social competence, and self-efficacy by addressing skills.
8. Provides functional health knowledge that is basic, accurate, and directly contributes to health-promoting decisions and behaviors.
9. Uses strategies designed to personalize information and engage students.
10. Provides age-appropriate and developmentally appropriate information, learning strategies, teaching methods, and materials.
11. Incorporates learning strategies, teaching methods, and materials that are culturally inclusive.
12. Provides adequate time for instruction and learning.
13. Provides opportunities to reinforce skills and positive health behaviors.
14. Provides opportunities to make positive connections with influential others.
15. Includes teacher information and plans for professional development and training that enhance the effectiveness of instruction and student learning.

Step 3: Use a Clear Process for Curriculum Development

In order to have a skills-based approach that supports the legislated content areas, health education leaders typically implement the following steps to build a local health education curriculum:

1. Review and analyze local/regional data, e.g., Youth Risk Behavior Surveillance System (YRBSS), Ohio Healthy Youth Environment Survey (OHYES!), or other public health data to determine how to address concerning data points in the health education classroom.
2. Identify how much time, on average, is allotted to health education at each grade level span.
3. Determine what curriculum standards will address the concerning data points.
4. Determine which Health Behavior Outcomes (HBOs), as specified within the Centers for Disease Control and Prevention's Health Education Curriculum Analysis Tool (HECAT) will address the concerning data points at each grade level.
    a. Examine the OAHPERD Health Education Model Curriculum. Utilize the Priority Charts to determine standards that are essential and supportive in each topic area. Determine learning outcomes that will be achieved at each grade level for each topic.

5. Review what content areas are required by the Ohio Revised Code (ORC) at: http://education.ohio.gov/getattachment/Topics/Learning-in-Ohio/Health-Education/Overall-Health-Education-Curriculum-Requirements.pdf.aspx
6. Identify what concepts and skills will be taught during each grade level. An example of this includes how interpersonal communication skills, like negotiation skills, may be introduced and practiced in 3rd grade within a bullying prevention unit, as well as reinforced in middle school within a unit on healthy eating/nutrition, and finally mastered in high school during a unit on healthy family relationships. Align assessments with learning outcomes. Develop a local curriculum, including unit and lesson plans, that are aligned with the learning outcomes. Explore instructional strategies, instructional technology, and how to meet the needs of diverse learners to create a local curriculum that accommodates students' needs.
7. The Ohio Association for Health, Physical Education, Recreation and Dance (OAHPERD) can be another resource for providing professional development for teachers, as well as support, to ensure schools are meeting the health education requirements outlined in the ORC. Please visit www.ohahperd.org for additional information.

Guide to the OAHPERD Model Curriculum

The OAHPERD Health Education Model Curriculum is a tool to assist districts developing local curriculum. The OAHPERD Health Education Model Curriculum is aligned with the National Health Education Standards (NHES) (Joint Committee on National Health Education Standards 2007). These standards have been used extensively in other states, have served as a model for Ohio schools, and have guided additional prevention efforts to help develop students' health literacy.

The OAHPERD Health Education Model Curriculum includes the following components:

1. Learning Outcomes – Standards, Benchmarks, and Indicators for Grades K–12.
2. Content Frameworks – Explanation of the knowledge and skills within each topic area to support the achievement of the learning outcomes.
3. Standards Priority Charts – Tables that overview the Essential and Supportive learning outcomes in each grade band.
4. Additional Support Materials – Materials that support the implementation of the curriculum, including instructional strategies to support diverse learning needs, technology, and local curriculum development.

1. Learning Outcomes: The learning outcomes include standards, benchmarks, and content indicators. Learning outcomes are aligned with the National Health Education Standards (NHES).

- *Standards* – Standards are outcomes to be achieved by the end of the K–12 curriculum.
    - **Standard 1**. Students will comprehend concepts related to health promotion and disease prevention to enhance health.
    - **Standard 2.** Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.
    - **Standard 3.** Students will demonstrate the ability to access valid information, products, and services to enhance health.
    - **Standard 4.** Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.
    - **Standard 5.** Students will demonstrate the ability to use decision-making skills to enhance health.
    - **Standard 6.** Students will demonstrate the ability to use goal-setting skills to enhance health.

- **Standard 7.** Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.
- **Standard 8.** Students will demonstrate the ability to advocate for personal, family, and community health.

- *Benchmarks* – Learning outcomes to be achieved by the end of the grade band. Benchmarks are common learning outcomes across topics as well as building blocks for meeting the standards. *Grade Bands* include K–2, 3–5, 6–8, and High School.
  - *Benchmark Example*: Standard 4.1.5 Demonstrate effective verbal and nonverbal communication skills.
  - Benchmarks are general in nature and do not address specific health topics. Benchmarks provide a useful framework to show the alignment of the learning outcomes across health topics.
- *Indicators* – Learning outcomes for each grade level within a topic area. Meeting these indicators would be the first step toward achieving the benchmarks and standards. The OAHPERD Health Education Model Curriculum presents indicators for each aligned topic area in health education.
  - *Example*: Standard 4.1.ATOD.1.5 Demonstrate effective verbal and nonverbal communication to avoid riding in a motor vehicle with a driver who has been drinking alcohol.
  - Indicators are grade-level outcomes specific to the topic.
  - The OAHPERD Health Education Model Curriculum presents content indicators for each topic area organizer:
    - Alcohol, Tobacco and Other Drugs (ATOD)
    - Healthy Eating (HE)
    - Human Growth & Development (HGD)
    - Healthy Relationships (HR)
    - Mental & Emotional Health (MEH)
    - Personal Health & Wellness (PHW)
    - Safety (SAFE)
    - Violence Prevention (VP)
- *Learning Outcomes Coding System:*

  Standards and Benchmarks Coding System
  - The first number represents the **standard** being addressed.
  - The second number refers to the **benchmark** being addressed.

- The third number refers to the **grade band** in which the benchmark is completed.
- *The final number will always represent the **grade level** at which the outcome is achieved.
    - Example (S1.2.2) – Standard 1. Benchmark 2. 2nd Grade

Grade Level Indicator: Coding System

- Indicators are grade-level outcomes specific to the topic.
- *Topic Areas:*
    - The OAHPERD Health Education Model Curriculum presents content indicators for each topic area organizer:
        - Alcohol, Tobacco and Other Drugs (ATOD)
        - Healthy Eating (HE)
        - Human Growth & Development (HGD)
        - Healthy Relationships (HR)
        - Personal Health & Wellness
        - Safety (SAFE)
        - Violence Prevention (VP)
    - *Indicator Numbering System*
        - The first number represents the **standard** being addressed. (e.g. Standard 3 = S3)
        - The second number refers to the aligned **benchmark** being addressed.
        - The letters correspond to the **topic area**.
        - The third number represents the **indicator number**. Indicators are grade-level outcomes specific to the topic.
        - The fourth and final number represents the **grade level.**
        - Example (S4.B1.ATOD.1.G5)
            - Standard 4. Benchmark 1. Within Alcohol, Tobacco and Other Drugs. Indicator 1. Grade 5.

2. **Content Frameworks –** Content Frameworks provide explanations of the knowledge and skills represented in the learning standards. Content Frameworks are present for each of the topic areas. They are intended to support the development of unit and lesson plans.

- *Content Framework Components:*
    - Learning Outcomes – Standards, benchmarks and indicators by topic area.
        - Learning outcomes are organized by "Essential" and "Supportive."
            - *Essential (E)* – The standard is prioritized, receives emphasis, and should be met while teaching the designated topic.
            - *Supportive (S)* – The standard is aligned with the unit topic. The standard could be met if additional time or resources are available.
    - Content Elaboration – Description of essential outcomes, functional knowledge, and key concepts for current, future, and previous grade bands.
    - Functional Understandings and Skills – Description of functional understandings and skills within the content area for the grade band.
    - Resources – Additional support and free and publicly available resources.
    - Connections
        - Skills Connections in Health Education – Connections between skills in other topics within health education.
            - Example – Communication Skills (Standard 4) are developed in both ATOD and Violence Prevention.
        - Interdisciplinary Connections – Making connections with other academic content areas, such as Math, English Language Arts, and Science.

3. Standards Priority Charts – Essential and Supportive Standards

- Each topic area has the opportunity to align most if not all of the standards, but schools have limited allocated time for health education. To assist schools in making local curriculum decisions, the Health Education Model Curriculum Priority Tables identify "Essential" and "Supportive" standards within each topic area to prioritize learning outcomes.
    - *Essential (E)* – The standard is prioritized, receives emphasis, and should be met while teaching the designated topic.
    - *Supportive (S)* – The standard is aligned with the unit topic. The standard could be met if additional time or resources are available. Supportive suggest the skill could be enhanced, reinforced or practiced.
    - * - Identifies a standard that is not aligned with the topic area, or a learning outcome that is not developmentally appropriate for the grade band.
- The "Essential" and "Supportive" designation is only a suggestion to facilitate the curriculum development process.

- Priority Charts are presented for each grade band and for each grade level in Grades K–8. High school is only presented for the one semester required for graduation.
- When planning local curriculum each skill standard (Standards 2–8) must be designated "Essential" in at least **two** topic areas across the grade band.
- The Standard Priority Charts are not prescriptive. Districts should participate in a process to determine "Essential" and "Supportive" standards to meet their students' needs.

OAHPERD Health Education Model Curriculum Development Process

The OAHPERD Health Education Model Curriculum was developed during the 2018-2019 school year. The project was made possible by support from the Mt. Sinai Healthcare Foundation. The development process began with the selection of a Leadership Team and Writing Teams. The development process was informed and guided by the effort of the Advisory Committee, which was convened by the Health Policy Institute of Ohio. Drafts of the various components were collected from various stakeholders using online tools and in-person meetings. The OAHPERD Health Education Model Curriculum Leadership team refined the various components of the curriculum based on public feedback. This section will overview the curriculum development process and recognize those whose time and effort helped to build this resource.

Leadership Team

The Leadership Team (See Table 2) included experts in Ohio from various backgrounds, experiences, and leadership positions in health education. Members of the Leadership Team were invited to join the group based on their significant contributions to health education at the state and national levels.

- Responsibilities of Leadership Team:
    1. Lead the development of the OAHPERD Health Education Model Curriculum, including learning outcomes, priority charts, scope and sequence, content frameworks, and support materials.
    2. Serve as leaders for one grade band for the Learning Outcomes and Content Frameworks.
    3. Align materials and check for developmentally appropriate progressions between and within grade bands.
    4. Determine terminology, definitions, key concepts, and guiding principles.
    5. Consider Advisory Committee recommendations.

Table 2. Leadership Team.

Name	Responsibility	Position
Kevin Lorson	Project Manager	Professor, Health & Physical Education Teacher Education Program, Wright State University
Jessica Lawrence	Curriculum Consultant	Cairn Guidance
Susan Telljohann	Curriculum Consultant	Emeritus Faculty, University of Toledo Author – Health Education Curriculum Analysis Tool
Judy Jagger-Mescher	K-5 Leader	Instructor, Health Education Program Director (Retired), Wright State University
Joe Dake	Grade 6-8 Leader	Chair/Professor, School of Population Health, University of Toledo
Tina Dake	High School Leader	Health Education Teacher, Whitmer High School
Holly Raffle	Curriculum Consultant	Associate Professor, Voinovich School of Leadership, Ohio University
Trevor Thomas	Curriculum Consultant	Superintendent, Heath City Schools

Writing Teams

Two Writing Teams were formed to build the OAHPERD Health Education Model Curriculum materials – the Learning Outcomes Writing Team and Content Framework Writing Team. The Learning Outcomes Writing Team was tasked with developing the learning outcomes, including the standards, benchmarks, and indicators. The Content Framework Writing Team was tasked with developing Content Frameworks and aligning the learning outcomes with the identified topics.

Learning Outcomes Writing Team. A call for applications was made in June 2018. A total of 35 applicants submitted materials. The team was selected based on credentials, experience, grade band, and geographic area. The team (See Table 3) was organized by grade band and led by a member of the Leadership Team. The Learning Outcomes Writing Team was convened regularly by their grade band leader. Many of the meetings were conducted online because the team was represented by members from across the state. The Learning Outcomes Writing Team assembled during the 2018 OAHPERD Convention to finalize an initial draft of the learning outcomes. The team continued to meet as other components of the OAHPERD Health Education Model Curriculum were developed.

Table 3. Learning Outcomes Writing Teams.

Name	Position
Grades K-5	
Judy Jagger-Mescher	Instructor (Retired), Health & Physical Education Teacher Education Program. Wright State University
Beth Canfield-Simbro	Associate Professor, University of Mount Union
Joan Hlinomaz	School Nurse, Kettering City Schools
Melissa Smith	Assistant Professor of Instruction, University of Akron
Barry Ward	Assistant Principal, New Albany Primary School
Grades 6-8	
Joe Dake	Chair/Professor. School of Population Health, University of Toledo
Aaron Merz	Health Education Teacher, Akron Public Schools
Maria Schneider	Health & Physical Education Teacher, Brecksville-Broadview Heights
Erin Sweeney-Hutzelman	Assistant Professor, Baldwin-Wallace University
Sue Borchers Zeanah	Health & Physical Education Teacher, Granville Schools
High School	
Tina Dake	Health Education Teacher, Whitmer High School
Brett Baisch	Health Education Teacher, Cleveland Bard High School
Ship Collins	Health Education Teacher, Orange High School
Meggan Hartzog	Instructor, Bowling Green State University
Cindy Zetterberg	Health Education Teacher, Sycamore High School

Content Framework Writing Team. The Content Framework Writing Team was purposed with developing the resources within the Content Framework and aligning the learning outcomes to them. The Content Frameworks were designed to provide additional information and resources to understand the content aligned with the learning outcomes and to support the development of a local curriculum. The Content Framework Writing Team was aligned with the topic area organizers and then combined into working groups to facilitate the efficient use of expertise and resources. The following topic area working groups were formed: Alcohol, Tobacco and Other Drugs (ATOD), Healthy Eating (HE), Human Growth & Development (HGD), Healthy Relationships (HR), Personal Health & Wellness, Mental and Emotional Health (MEH), and Safety (S) and Violence Prevention (VP).

Leaders of each Content Framework working group were members of the OAHPERD Health Education Model Curriculum Learning Outcomes Writing Team and are faculty members within Ohio's Health Education Teacher Education programs (See Table 4). A call for Content Framework Writing

Team members was made by OAHPERD in January 2019, resulting in a total of 14 additional applications. The applicants from the Learning Outcomes group were reconsidered for the Content Framework groups. Additional members outside the initial applicants were recruited to join the Content Framework groups based on expertise, skills, and location to meet the diverse needs of the OAHPERD Health Education Model Curriculum project. Content Framework groups met regularly from January to May 2019. Group leaders met regularly with the Project Manager and Leadership Team while developing the Content Frameworks. The Content Framework Leaders and Grade Band Leaders met in May 2019 in Columbus to refine the initial draft and align the Content Frameworks with the Learning Outcomes.

Table 4. Content Framework Writing Teams.

Alcohol, Tobacco, and Other Drugs (ATOD)	
Name	Position
Erin Sweeney-Hutzelman	ATOD Leader, Assistant Professor, Baldwin-Wallace University
Karen Abel-Jepsen	Prevention Specialist
Cathy Hewitt	Lake County General Health District
Bethany Archer	Health & Physical Education Teacher, Van Buren Local Schools
Healthy Eating (HE)	
Meggan Hartzog	HE Leader, Instructor, Bowling Green State University
Jan Diamond	American Dairy Association
Jim Smith	Health Education Teacher, Northmont High School
Stephanie Moisio	Health Education Teacher, Bedford High School
Human Growth & Development (HGD), Healthy Relationships (HR), Personal Health & Wellness (PHW)	
Andrea Traylor	HGD, HR, PHW Leader. Visiting Professor, Public Health Education, Wright State University
Ashley Glass	Dayton & Montgomery County Public Health
Windai Tolbert	Dayton & Montgomery County Public Health
Nathan Cline	Health & Physical Education Teacher, Lakota School District
Stacey Ullmer	School Nurse - Kettering St. Charles School

Mental & Emotional Health (MEH)	
Melissa Smith	MEH Leader. Assistant Professor of Instruction, University of Akron
John Godfrey	Health Education Teacher, Marion Harding High School
Marla Terrell	Health Education Teacher, Fairless High School
Nikolaus Schweikert	Health Education Teacher, Canton South High School
SAFE (S) & Violence Prevention (VP)	
Beth Canfield-Simbro	SAFE & VP Leader. Associate Professor, University of Mount Union
Cathy Ramstetter	School Health Consultant
James Scott	Franklin Heights High School
Lisa Longino	Cleveland Metro School District

Advisory Committee

The Health Policy Institute of Ohio (HPIO) convened the Advisory Committee to provide input and guidance on the creation, components, and structure of the Health Education Model Curriculum to ensure it met the unique and diverse needs of Ohio. The Advisory Committee was intended to represent the various health education stakeholder groups. The Advisory Committee met on June 21, 2018, December 12, 2018, and June 17, 2019. A total of 53 members representing 40 organizations from the education, health, and community sectors attended at least one of the meetings.

Each meeting played a specific role in the development of the curriculum. Meeting 1 established the structure of the document, clarified key terms, and provided feedback regarding the initial learning outcomes. Meeting 2 reviewed the first draft of the Learning Outcomes, clarified key questions from the Writing Teams, and addressed any other items impacting the development of the curriculum. Meeting 3 reviewed the Learning Outcomes, Priority Charts, and structure of the Content Frameworks. Members provided feedback about the Model Curriculum in grade band groups before a large group discussion. The Advisory Committee addressed the dissemination of the materials and the potential impact of the project on other state and local initiatives. HPIO produced an Executive Summary that included a logic model and a summary of the process used to engage stakeholders.

Table 5. Organizations attending Advisory Committee Meetings

Buckeye Association for School Administrators	Ohio Afterschool Network
The Center for Community Solutions	Ohio Association of Elementary School Administrators
Children's Defense Fund – Ohio	Ohio Chapter, American Academy of Pediatrics
EVERFI	Ohio Department of Health

Heath City Schools	Ohio Excels
Interact for Health	Ohio PTA
Live Healthy Appalachia	Ohio School Boards Association
Local Matters	Ohio School Counselors Association
Miami Valley Hospital	Ohio Senate
Mission2Move	Ohio Society of Public Health Education
Mt. Sinai Health Care Foundation	Ohio University
Nationwide Children's Hospital	Ohio Mental Health and Addiction Services
Northwest Local School District	Prevention Action Alliance
Ohio Association of Community Health Centers	St. Vincent Charity Medical Center
Ohio Department of Education	The Center for Balanced Living
Ohio Education Association	The Ohio State University
Ohio Attorney General's Office	University of Cincinnati
Ohio Academy of Family Physicians	Van Buren Local Schools

Timeline

Date	Description
April 2018	Project proposal approved by the Mt. Sinai Foundation.
May 2018	Leadership and Learning Outcome Teams assembled.
June 2018	Advisory Team Meeting 1.
June 2018	Learning Outcomes Writing Team Assembled.
Aug. – Nov. 2018	Learning Outcomes Writing Team creates first draft of learning outcomes.
December 2018	Advisory Team Meeting 2
January 2019	Learning Outcomes revised based on Advisory Team recommendations.
January 2019	Content Framework Groups assembled
Jan. – May 2019	Content Framework Writing Teams develop Content Frameworks and Priority Charts
June 2019	Advisory Team Meeting 3
July 2019	Revisions of Model Curriculum Materials and alignment check by Leadership Team. Support materials developed and reviewed by Leadership Team.
August 2019	Document published on OAHPERD Website – www.ohahperd.org

Learning in Ohio: Health Education

The Ohio Department of Education (ODE) provides guidance across all content areas. The ODE has a limited scope of influence on health education, because health education standards remain under the purview of the Ohio General Assembly; thus, the ODE provides guidance only for health education requirements for specific topics and to meet graduation requirements (http://education.ohio.gov/Topics/Learning-in-Ohio/Health-Education). The OAHPERD Health Education Model Curriculum aligns with the materials and support from the ODE. Learning in Ohio (http://education.ohio.gov/getattachment/Topics/Learning-in-Ohio/FACTS_StandardsCurrAssResources.pdf.aspx) provides an overview of learning standards, model curricula, assessments, and resources. This section will overview specific topics useful in supporting the implementation of the local health education curriculum, including teaching skills-based health education, assessments, instructional technology, integrating social-emotional learning, and connections to prevention programming.

Implementing a Skills-based Health Education Curriculum

Skills-based Health Education

The focus of K–12 health education has evolved from mere knowledge acquisition to skill development. It is imperative for teachers and curriculum directors to understand the principles of skills-based health education. Skills-based health education is a formidable tool for addressing health-risk behaviors as well as for achieving and sustaining health-related behavior change (Hale, Fitzgerals-Yau and Vine 2014).The skills-based approach focuses on the developmental of functional knowledge, health-enhancing personal beliefs, and seven essential skills. The skills developed in skills-based health education include analyzing influences, access valid health information, interpersonal communications, decision-making, goal-setting, and advocacy for self and others. The skills-based approach combines critical and creative thinking with student-centered strategies that trigger more participation and discussion as well as multiple opportunities to practice each skill in a variety of health content areas. A strong relationship exists between exemplary skills development and health-related behavior change: the goal of health education.

Skills can transfer across multiple topic areas within health education. The functional knowledge of a topic area provides the framework for teaching a skill. For example, the skill of interpersonal

communications (Standard 4) could be taught and practiced in the content area of violence prevention with an emphasis on conflict management. Standard 4 might also be taught in ATOD with an emphasis on refusal skills. Using the example of violence prevention, one way to assess student proficiency in conflict management would be to provide a violence-related scenario and then ask the students to demonstrate effective conflict management skills to address the situation in that scenario. In fact, nearly all seven skills standards could be taught in any of the health education content areas.

Skills-based health education requires a sequential, comprehensive, five-step skills development process, including:

1. Discuss the importance and relevance of the skill to the students' lives as well as how the skill relates to other learned skills.
2. Present the steps (process) for developing the skill.
3. Model the skill for the students.
4. Practice the skill using real-life scenarios (whole group, then partners).
5. Provide feedback and reinforcement.

All five steps must be included when teaching the skill to develop students' ability to apply the skill independently. A common misconception is the belief that a health-related skill has been taught when only the steps or process of the skill have been reviewed and assessed with students. Skills-based health education structures lessons and learning experiences that integrate all five steps. When skills are developed and reinforced with multiple practice opportunities, students can develop self-efficacy. Developing self-efficacy is primary to adopting healthy behaviors as part of a lifestyle (Bandura 2004). Self-efficacy is the belief in one's ability to successfully do something and is a key element in several health behavior theories/models. To achieve our goal of having Ohio students lead lives of health and wellness, the health education curriculum must consistently and correctly provide learning experiences that develop the seven health-related skills for students and help them adopt healthy behaviors.

Skills-based Instructional Approaches and Strategies

A skills-based approach to health education calls for active student engagement in real-world, authentic activities. The first of eight health education standards focuses on concepts, or what students need to know about health. The remaining seven standards focus on specific skills that, when mastered, have the potential to optimize health and well-being. When teaching each of the seven skills standards, teachers utilize a variety of strategies that make learning about health relevant to students. The following section provides examples and resources of instructional strategies to support each standard. Standards 2-8 should utilize the five-step skill development process with any strategy outlined in this section.

Standard 1 – Students will comprehend concepts related to health promotion and disease prevention.

The basic foundation of all the health skills is the ability to comprehend concepts. Students need accurate, reliable, and credible knowledge to use, maintain, or develop healthy behaviors. A curriculum solely focused on knowledge of factual information will not change behavior. Although a curriculum that is only based on concepts will not change health behaviors, the pairing of this standard with the seven skills standards will bring about the desired change in student health practices.

Standard 2 – Analyzing Influences: Students will analyze the influence of family, peers, culture, media, technology, and other factors on health behaviors.

Multi-media approaches are useful in teaching students how to analyze influences, especially when examining popular cultural influences. Exposing students to videos and recordings of popular music, advertising, and web-based platforms (Instagram, Pinterest, Facebook) is an excellent way for students to examine the messages they are bombarded with, messages that serve to formulate their understanding of themselves and the world, and which in turn may influence their behavior. Other methods include surveys of peers and the use of personal response systems that allow students to understand the actual opinions and behaviors of their peers and to dispel inaccurate perceptions of what their peers are doing. Using the data gathered from peers, students can create social norm campaigns. Research demonstrates that the use of student-led social-norming campaigns is an effective strategy for promoting healthy peer behaviors related to tobacco, alcohol, other drug use, bullying, sexual violence, and sexuality. Social norm campaign examples: Substance Abuse, Social Marketing Campaign, and Bullying.

Standard 3 – Accessing Information: Students will demonstrate the ability to access valid information, products, and services to enhance health.

When teaching students how to access health information and services, teachers provide opportunities for students to utilize actual resources to locate credible information and determine whether sources are valid, reliable, and unbiased. Working in the media center, gathering information, and performing computer searches allow students the ability to demonstrate knowledge about how to access credible information so they can do so throughout their lives. Resources for judging the credibility of sources include the CRAAP Test and other lessons that teach how to recognize bias in media sources.

Taking students on field trips to health facilities, grocery stores, farms, and other local health-related sites exposes students to community resources so they know where to go to obtain valid and reliable health products and services. Guest speakers can also inform students about useful health products and services in their community when field trips are impractical.

Standard 4 – *Interpersonal Communication: Students will demonstrate the ability to use interpersonal communication skills to enhance health and avoid or reduce health risks.*

Students learn a variety of communication skills, including refusal skills, conflict resolution strategies, empathy, how to be active listeners, how to use I-messages, as well as how to effectively deliver messages through an assertive, respectful voice, eye contact, and body language. Strategies for teaching communication skills include modeling through demonstration or the use of videos or other media that show effective examples of interpersonal communication. Once students understand what effective communication skills look and sound like, they can be given scenarios and then create role plays, scripts, and even videos to demonstrate their ability to use interpersonal communication skills in real-world settings and circumstances. Click here for information about teaching interpersonal skills and here for more skill building activities.

Standard 5 – *Decision-Making: Students will demonstrate the ability to use decision-making skills to enhance health.*

There are many different decision-making models, though most have common elements, which include identifying the problem, examining possible actions, identifying positive and negative consequences of each action, and finally arriving at a health-enhancing decision. Strategies for teaching decision-making include simulations, critical incidents, open-ended stories, and case studies. It should be pointed out that decision-making is an important competency of social and emotional learning. Further, these strategies have been effective in enhancing student health and reducing the prevalence of drug use, violence, and high-risk sexual behaviors (Payton, Wardlaw, Graczyk, Bloodworth, Tompsett, Weissberg, 2009). For additional support on teaching decision-making to adolescents, click here, and on the decision making process, click here.

Standard 6 – *Goal-Setting: Students will demonstrate the ability to use goal-setting skills to enhance health.*

Students must learn how to go through the process of setting a goal, and then learn to express the goal in explicit, measurable, achievable, and timely terms (RMC Health). As students learn about any health issue or content area, it makes sense for them to set reasonable goals for themselves once they understand the value in making a behavior change or improving their overall health. Giving students scenarios, case studies, and videos can give them practice using the goal-setting process to set a goal with a healthy outcome as its aim.

Standard 7 – Self Management: Students will demonstrate the ability to practice health-enhancing behaviors and avoid or reduce health risks.

Self-management skills involve becoming proficient in everyday health behaviors. A few examples include performing first aid, preparing low-fat snacks, practicing basic hygiene behaviors, wearing seat belts and helmets, and planning a nutrient-rich daily diet. The most obvious strategy for teaching self-management skills is to break any of these skills into steps, demonstrate the steps, and then give students practice performing the skills needed to demonstrate proficiency. Generally, check-lists are helpful when introducing and demonstrating each step needed to perform the health skill effectively. Some skills can be taught through video tutorials and guided learning.

RMC Health also shares a tutorial for teaching self-management skills at elementary school, as well as in the middle grades and at the high school level. They describe the five steps in the development of skills: identify the need for behavior change, identify resources/information needed to make the behavior change, practice the needed skills, set your intention and make the change, and reflect/adjust to form a habit. Click here to view additional information for self-management skills.

Standard 8 – Advocacy: Students will demonstrate the ability to advocate for personal, family, and community health.

When students are taught about advocacy, it will involve teaching them how to gather pertinent information and then use that information to create awareness of a problem or issue. Once students are taught the elements of advocacy, there are any number of ways for them to express their advocacy through the creation of projects. These may include writing news articles or letters to community leaders, creating posters, performing skits, delivering peer instruction, creating videos or songs or other media-based programs, producing a documentary, using social media (Twitter, Instagram, or Pinterest), and attending and delivering messages at meetings of the school board or at city/county council meetings. While students may create these projects independently, advocacy projects often involve group work.

Diverse Learners in Health Education

The Ohio Department of Education (ODE) provides general guidance for meeting the needs of diverse learners. Diverse learners often fall into one or more of these three categories: English Language Learners, Students with Disabilities, and Gifted Students. The ODE provides general information and resources for the three categories. Click on the links below to access the ODE resources:

English Language Learners are students who represent a variety of home/native languages, cultural backgrounds, and levels of English proficiency. Click here to view general information and resources for these learners.

Students with Disabilities in Ohio are identified as possessing one of 13 disabilities as defined by the Individuals with Disabilities Education Act (IDEA). Click here for related information and general resources.

Gifted Students are those who perform, or show the potential to perform, at high levels of accomplishment in the areas of academic achievement, cognitive abilities, creative thinking and/or the visual or performing arts, as compared to others of their age, experience, or environment. Click here for related information and general resources for gifted students.

Instructional Technology

Technology is an important consideration in health education, impacting our students' lives and how we deliver health education. Technology plays a significant role in our students' lives as a tool to communicate, gather information, and engage in our world. Aspects of technology can be seen in the OAHPERD Health Education Model Curriculum Learning Outcomes. Standards 2, 3, and 5 all have specific outcomes aligned with the use of technology to enhance health.

The OAHPERD Health Education Model Curriculum is designed to enhance curriculum and instruction. Instructional technology is a vehicle used to enhance student learning. The ODE provides additional resources for instructional technology within English Language Arts that apply across content areas. Instructional technology resources for health education can be found here:

Assessment

Assessment is a process whereby educators learn more about their students' progress. The assessment process includes not only measuring student learning but also evaluating, identifying strengths and areas to improve, and determining strategies or opportunities to improve. Assessments include traditional tests but also involve a variety of assessment tools and activities that help teachers determine whether a student needs additional support or practice, and when he or she is ready to move ahead in the learning process.

Health education in Ohio does not have a prescribed statewide test or assessment. Teachers should engage in a collaborative process when developing a local curriculum to determine assessments that could be used to track student progress toward the learning outcomes. The HECAT provides a useful resource for additional information about assessment in health education.

Developing Local Curriculum

The OAHPERD Health Education Model Curriculum is designed to guide local curriculum development. The goal of the OAHPERD Health Education Model Curriculum is to provide a framework from which local curricula could be developed, allowing for the inclusion of content and concepts that are appropriate for local needs. The suggested process for local curriculum development is grounded in the principles of backward design. Backwards design begins with the student outcomes, creating assessments, choosing skills or topics, creating a scope and sequence, unit plans, and then designing lesson plans. Tools such as the OAHPERD Model Curriculum, Characteristics of Effective Health Education Curriculum, and the Health Education Curriculum Analysis Tool (HECAT) are important to the development and implementation of local curriculum. Local districts should develop a team of diverse stakeholders, invest in the process, plan for professional development and dedicate resources to implement a skills-based health education curriculum. Health Education Teachers should be engaged and assume leadership positions in a curriculum development process.

Step 1. Get to Know the Students and Community: Review and analyze local/regional data.

An effective health education curriculum is one that best meets the needs of students, school and community. Getting to know the students and community is key to developing a curriculum that is relevant, meaningful and meets local health priorities. Data is a useful tool to identify relevant and meaningful outcomes, as well as the functional knowledge with health topics that provides the context for teaching each skill. Data sources could include student-level, school-level, community or neighborhood, state and national data. Student level data could be collected using surveys, focus groups, interviews and student assessments. Student data could be available from surveys such as the Youth Risk Behavior Surveillance System (YRBSS) and Ohio Healthy Youth Environment Survey (OHYES!). School level data is summarized data about students such as attendance, discipline, immunizations, or health services. Community data might include data from the local public health department of Community Health Assessments. State and national data sources could include vital statistics, foundation reports, or government records. Districts should take time to consider data sources, collect data, analyze and interpret data to inform local curriculum decisions. Teachers should also get to know their students and community by using data; community mapping; talking with community members, parents, and students; engaging in community events, councils and organizations; and listening to student voices. Another consideration impacting local curriculum are state and local health education requirements.

Step 2. Identify and Prioritize Learning Outcomes

Determine which Health Behavior Outcomes (HBOs), as specified within the Centers for Disease Control and Prevention's Health Education Curriculum Analysis Tool (HECAT) will address the concerning data points at each grade level. Connect the HBOs to the OAHPERD Model Curriculum Learning Outcomes. All skills are important for students to develop, but all skills cannot be addressed in every topic area due to time constraints or alignment with outcomes. The Priority Charts included in the Model Curriculum could be a useful tool to determine the standards aligned with each of the identified health education topics. The Priority Charts also identified standards that are Essential and Supportive to guide local decisions about the skills that could be taught in each topic area. Essential skills are those to be met within the grade band or grade level. Supportive are those skills that could be addressed with additional resources or emphasis.

Step 3: Determine Assessments

Consider how the learning outcomes will be measured. Health Education assessments are determined locally, with no additional guidance from the ODE. Assessments will be useful to determine student progress towards learning outcomes and provide useful information on the curriculum development process. Benchmarks assessments can be useful to understand student progress and growth at the end of the grade band, especially towards the development of skills. Assessments should utilize a variety of tools beyond just written tests. Performance tasks are recommended to assess the skills within Standards 2-8. The HECAT provides a useful resource for additional information about assessment in health education.

Step 4: Identify Local Resources and Instructional Time

The curriculum planning process is impacted local and state requirements and by the resources available. Ohio has specific requirements for topics to address within health education. The only specified time requirements are .5 units (minimum of 60 hours) for high school graduation. No time requirement is specified for Grades K-8. Carefully consider the current time allocated for health education in each grade level and grade band. The curriculum development process would have to revisit and refine targeted learning outcomes based on time constraints. If additional needs or learning outcomes cannot be addressed within the allocated time for health education, continue to explore partnerships with other prevention and health education programs. Explore health education-related resources are available from the various school and community stakeholders within the Whole School, Whole Community, Whole Child could support continued development and application of the health behavior outcomes.

Step 5: Determine Topics and Content

The next step is to determine the skills, topics or themes, and functional information students need to achieve the learning outcomes. Within this step, the district must consider list of required topics in the Ohio Revised Code. The OAHPERD Model Curriculum utilized the HECAT Content Modules titles to group health topics into themes (e.g. Safety, Violence Prevention, Healthy Eating). Deciding topics and content within the curriculum can be a challenging task because of the perceived need to try to teach every topic into the limited amount of time available to health education. A thoughtful, well-designed curriculum could alleviate some concerns as the focus is not to address every health topic in every year, but to address skills and topics systematically across a K-12 curriculum. An example of this includes how interpersonal communication skills, like negotiation skills, may be introduced and practiced in 3rd grade within a bullying prevention unit. Additional communication skills could be reinforced in middle school within a unit on healthy eating/nutrition. Communication skills such as empathy and refusals skills could be mastered and applied to a healthy lifestyle in high school during a unit on healthy family relationships.

Step 6. Identify what concepts and skills will be taught during each grade level.

Once the topics are identified the next step is to align them with the learning outcomes and skills. Topics identified in Standard 1 provide the content for students to apply the skills (Standards 2-8). Please consider the recommendations for addressing skills within your curriculum:

1. Each of the standards is addressed in each grade levels.
2. Each skill is addressed at least twice in each grade level.

The curriculum team could create a table that would identify when a skill is introduced, reinforced in each grade level. Once the concepts and skills taught during each grade level have been identified, the process should align assessments with learning outcomes.

Step 7. Create a Scope & Sequence

A scope and sequence outlines what content will be covered and when it will be covered in each grade level. A local scope and sequence is not intended to be specific and prescriptive, but a framework to outline what is being taught (scope) and when it is being taught (sequence). Teachers would have the flexibility to modify the scope and sequence to meet students' needs. A scope and sequence includes the aligned learning outcomes, assessments, and skill addressed. An effective scope and sequence ensures that all skills build progressively on one another, and that students will have sufficient time and opportunity to develop skills across topics and grade levels. A district scope and sequence is a living document that is fluid, dynamic and regularly reconsidered to meet student, school and community needs.

Step 8: Implementation & Professional Development

After the scope and sequence has been created the final step is for health education teachers to develop unit and lesson plans. There are many different approaches to develop unit and lesson plans. Refer to local guidelines to develop unit and lesson plans using backwards design that meet district expectations and teachers' needs. Teachers should determine the learning outcomes, assessments, and then develop aligned and engaging learning activities to meet students' needs. As with all aspects of curriculum development, dedicate time and energy to review assessment data, collect additional data and reflect on how the curriculum could be refined to meet student needs.

As local districts and teachers engage in the curriculum development process, teachers and staff will need professional development to retool their knowledge and skills. The Ohio Association for Health, Physical Education, Recreation and Dance (OAHPERD) can be a resource to provide professional development for teachers, as well as support to ensure schools are meeting the health education requirements outlined in Ohio Revised Code. Please visit www.ohahperd.org for additional support. Curriculum development is an ongoing process, districts should allow time for health educators to meet regularly to reflect, consider and refine the local health education curriculum.

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